

PEDIATRICS.

UNDER THE CHARGE OF

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Acquired Venereal Infections in Children.—F. POLLACK (*Johns Hopkins Hospital Bulletin*, 1909, xx, 142) states that yearly in Baltimore there are about 1000 cases of acquired venereal infection in children, thus proving that they are far more common than the medical profession or the laity realizes. The cause of most of the outrages upon children is found in the superstition that a person infected with either syphilis or gonorrhoea may get rid of it by infecting another, and preferably an "untouched virgin." Thus, a defenceless child is the most natural victim. Pollack has seen 189 such cases personally in the last six years. The infections run a milder course as regards complications than in adults; the duration of the disease is as long. The complications are as follows: Urethritis, 36; bubo, 28; secondary syphilis, 29; peritonitis, 19; bleeding, 16; primary sores, 7; pregnancy, 6; Bartholinitis, 3; arthritis, 3; ophthalmia, 3; etc. As treatment does not seem to influence the disease, prophylaxis seems to be the most effective remedy. In the secretions gonococci can be demonstrated very readily.

The Treatment of Facial Paralysis Due to Mastoid Disease or to the Mastoid Operation.—F. SYDENHAM (*Brit. Med. Jour.*, 1909, i, 1113) reports the case of a boy, aged five years, in whom, during an operation for mastoid disease, the facial nerve was divided, resulting in complete paralysis of that side of the face. Two days later the wound was re-opened and an end-to-end anastomosis performed; when apposed a gap of about one-half inch was noticed; this was bridged with silkworm gut. Electricity was employed from the first, but no movement of any kind could be produced for three months, when slight movements of the *alæ nasi* of the affected side could be observed upon forced sniffing; the other facial muscles afterward gradually returned to full power. The boy has now recovered his normal expression; when at rest and when his facial muscles are thrown into action, it is difficult to tell that there has been any facial paralysis at all. Sydenham recommends this method of anastomosis in preference to the faciohypoglossal and to the facio-spinal accessory, as being more easily performed and better for the patient.

A Clinical Study of the Children of Tuberculous Parents.—J. A. MILLER and I. O. WOODRUFF (*Jour. Amer. Med. Assoc.*, 1909, lii, 1016) have made a study of 150 children of parents under treatment for pulmonary tuberculosis. The factors taken under consideration were the tuberculin test, pulmonary symptoms and signs, sputum examination, joint, bone, and other non-pulmonary lesions, the state of nutrition, hypertrophied cervical lymph nodes, tonsils, and adenoids. The following

are their conclusions: (1) In the children of tuberculous parents, who live in close association with such parents, a large proportion (in their series, 51 per cent.) become infected with tuberculosis. (2) The earliest manifestations are found in the lungs, and not in the superficial glands, bones, and joints. (3) The physical signs in children under ten years of age consist usually of persistent fine rales just without the midclavicular line in the fifth and sixth intercostal spaces; persistent sibilant rales in various parts of the chest make the diagnosis doubtful, but such cases should be regarded with suspicion. (4) The tuberculin tests, more particularly the hypodermic test in doses up to 5 mg., furnish the most reliable means of diagnosis. Of the local tests, the cutaneous is more reliable in children than the ophthalmic; it presents none of its possible dangers. (5) The ordinary examination of the sputum is almost no aid in the diagnosis of early tuberculosis in children. (6) Malnutrition is sometimes the only appreciable evidence of tuberculosis in children. (7) Hypertrophied tonsils and adenoids do not incline the balance in a suspected case toward a positive diagnosis of tuberculosis; further investigations of this subject, however, should be made. (8) The evidence that enlargement of the cervical lymph nodes is of aid as a determining factor in arriving at a diagnosis of tuberculosis in children is not conclusive.

Constitutional Eczema of Infants.—E. FEER (*Münch. med. Woch.*, 1909, lvi, 113) calls attention to chronic eczema occurring oftenest during the first few years of life and most commonly during the nursing period. In contradistinction to chronic eczema the acute form is frequently a true dermatitis; intertrigo is a true dermatitis only if co-existing with a disposition to eczema. The eczemas of older children rest oftenest upon a tuberculous base, and a positive tuberculin reaction may be obtained in almost every case. The real chronic eczema is undoubtedly a constitutional disease, but secondary dermal disturbance is quite common in their course. The two factors of importance in the development of chronic eczema are an inherited disposition and the type of nutrition; either of them may be the more important. There are two forms of chronic eczema to be found: the weeping, scale-forming eczema of the head, and the disseminated dry form. The first form is found oftenest in fat, pasty children, but even the healthiest may be affected. It begins in the scalp, spreading to cheeks and ears; it may spread to other parts of the body; there is very little itching. Overfeeding and constipation are common with these children and a spontaneous cure may be noted, when at the end of the first year a mixed diet is ordered for the child. The second form occurs almost exclusively in artificially fed infants; overfeeding is common and the patients are usually pale, thin, and flabby; chronic nutritional or intestinal disturbances are frequent. It manifests itself as discrete, dry, red, desquamating, infiltrating islands; also as papular and pustular foci. Weeping and scale formation are uncommon; part or all of the body may be involved. It is slow in development, itches, and is difficult to eradicate. Both the gouty diathesis and auto-intoxications have been blamed for this condition. Sudden deaths in children with such eczemas must be referred to "status lymphaticus" rather than to sepsis. Feer's